

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

06302

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH:

County SomersetCity or town Vinton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Vinton
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Daniel Wilmore Bailey

3. (b) Social Security Number

4. Sex male5. Color or race Col6. (a) Single, married, widowed, or divorced married6. (b) Name of ~~husband~~ or wife Sarah Hannah Bailey

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 15th 18778. AGE: Years 70 Months 1 Days 18 If less than one day _____ hrs. _____ min.9. Birthplace Somerset County, Md.
(Town, county, and state)10. Usual occupation Labor11. Industry or business Form Labor12. Name Grace Bailey13. Birthplace Somerset County, Md.14. Maiden name Margaret Bailey15. Birthplace Somerset Co., Md.16. Informant Sarah Hannah BaileyAddress Vinton, Md.17. Burial Date thereof July 6, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory VintonLocation Vinton, Md.18. Funeral director William H. James Jr.Address Princess Anne, Md.19. July 7, 1947 R. H. Johnson, M.D. Registrar

Date registered by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3rd 1947 at 8:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1947 to July 3rd 1947and that I last saw him alive on Monday June 29 1947

Immediate cause of death _____ DURATION _____

Chronic myocarditis 2 yrs.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

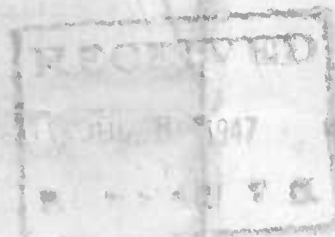
Signature Edgar G. MansormanAddress Princess Anne, Md. Date signed 7-5-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

06303

CERTIFICATE OF DEATH

Reg. Dist. No. 261

1. PLACE OF DEATH:

County Somerset
City or town Kingston, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County SomersetCity or town Kingston
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

William Robert Ballard

3. (b) Social Security Number

no4. Sex male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Mrs Cecilia Ballard7. Birth date of deceased (mo., day, yr.) May 8, 1877 6.(c) If alive, give age _____ years8. AGE: Years 70 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Kingston - Somerset - Maryland
(Town, county, and state)10. Usual occupation General Work11. Industry or business None12. Name John Ballard13. Birthplace Somerset Co.14. Maiden name Maria Fields15. Birthplace Worcester County16. Informant Mary HallAddress Marion St. Md17. Buried Date thereof July 16 - 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Kingston, Md.

Location _____

18. Funeral director George W. TilghmanAddress Marion, Md.19. July 16 47 John J. Meier
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 19 47 at 3 30 P. M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1 19 47 to July 1 19 47and that I last saw him alive on July 13 19 47Immediate cause of death Uremia Acute Dec 7 xufDue to Cerebral vesselsDue to Glomerulonephritis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work?

23. SIGNATURE George C. Callum M.D.Address Marion St. Md Date signed July 20 47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. MARITAL STATUS

11. EDUCATION

12. RELIGION

13. SOCIAL CLASS

14. RACE

15. ETHNICITY

16. NATURALIZATION

17. CITIZENSHIP

18. RESIDENCE

19. DECEASED'S SIGNATURE

20. DECEASED'S ADDRESS

RECEIVED
JUL 19 1947
SURVIVOR'S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 06304 265

1. PLACE OF DEATH:

County..... Somerset
 City or town..... Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:
Broadway
 How long in hospital or institution? ////////

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Somerset
 City or town..... Crisfield
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Broadway (Paper St.)
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ////////

3.(a) FULL NAME

Annie Bishop

3.(b) Social Security Number

4. Sex..... Female
 5. Color or race..... Colored
 6.(a) Single, married, widowed, or divorced..... Single
 6.(b) Name of husband or wife..... ////////
 7. Birth date of deceased (mo., day, yr.)..... January 28, 1920
 6.(c) If alive, give age..... /// years
 8. AGE: Years..... 27 Months..... 5 Days..... 18
 If less than one day..... hrs. min.

9. Birthplace..... New Church, Virginia
 (Town, county, and state)
 10. Usual occupation..... Seafood Worker
 11. Industry or business..... Crabs & Oyster
 12. Name..... Henry Bishop
 13. Birthplace..... Girdletree, Md.
 14. Maiden name..... Manie Hargis
 15. Birthplace..... New Church, Va.
 16. Informant..... Mrs. Henry Bishop
 Address..... Crisfield, Md.
 17. (Burial, cremation, or removal, Which?) Burial Date thereof..... July 21, 1947
 (month) (day) (year)
 Cemetery or crematory..... Lawsonia Cemetery
 Location..... Crisfield (Lawsonia) Md.
 18. Funeral director..... H. Harvey Bradshaw
 Address..... Crisfield, Md.

19. July 19 1947
 (Date read by registrar) Registrar Janice E. Spire

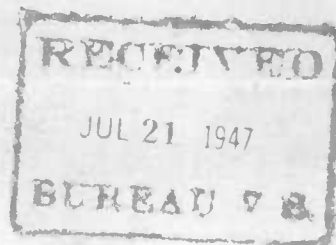
MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 16 1947 at 11:30 P
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19..... to 19.....
 and that I last saw him..... alive on 19.....

Immediate cause of death..... Embolism
 DURATION.....
 Due to..... Hemorrhage
 Due to..... Arterio Sclerosis
 Other conditions..... William H. Coulbourn, M.D.
 (Include pregnant months of death)
 Major findings of operations..... DEPUTY MEDICAL EXAMINER
FOR SOMERSET COUNTY, MD.
 Autopsy results..... No
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Manner of injury..... Natural Cause
 23. SIGNATURE..... W. H. Coulbourn
 Address..... Crisfield Md Date signed..... July 19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

06305

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH:

County Somerset
 City or town Mt Vernon
 (if outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Somerset

City or town Mt. Vernon
 (if outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Elizabeth Bozman

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Thomas J. Bozman7. Birth date of deceased (mo., day, yr.) December 24 6. (c) If alive, give age 24 years8. AGE: Years 89 Month — Days — If less than one day _____ hrs. _____ min.9. Birthplace Maryland (Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name William Andrews13. Birthplace Maryland14. Maiden name Mary Andrews15. Birthplace Maryland16. Informant Mrs. Mabel JohnsonAddress Princess Anne R.F.D.17. Buried Date thereof July 22-47

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St. Johns M.E.Location Deal Island Md18. Funeral director R. E. JohnsonAddress Deal Island Md19. July 22 1947 R.E. Johnson M.D. Registrar

(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19th 1947 at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death Myocarditis DURATION _____Due to Cerebral Sclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE R. E. Johnson M.D. or other _____Address Princess Anne Date signed 7/22/47

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JUL 24 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH:

County Somerset
 City or town Princess Anne, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset
 City or town Princess Anne, Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lora Marie Gaimos

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Where?)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Date thereof

(month) (day) (year)

Edwin JonesPrincess Anne Md. - Rt. #27/7 47 R. J. Johnson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 6th 1947 at 9:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 15th 1946 to July 6th 1947

and that I last saw her alive on

July 5th 1947

Immediate cause of death

Pulmonary Tuberculosis 10 months

Due to

Due to

Other conditions

Premature Birth of child

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Edwin G. Jones

Address

Princess Anne Md.Date signed 7.7.47

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JUL 8 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166

CERTIFICATE OF DEATH

Reg. Diat. No. 260

06307

1. PLACE OF DEATH: County <u>Somerset</u> City or town <u>Rural Pocomoke City Md.</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>seven years.</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Somerset</u> City or town <u>Rural Pocomoke Md.</u> (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION) 2. (a) If veteran, name war	
3. (a) FULL NAME <u>Timothy Wilson Laughery</u>		3. (b) Social Security Number	
4. Sex <u>Male</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>married</u>	
6. (b) Name of husband or wife <u>Bura Laughery</u>		6. (c) If alive, give age <u>27</u> years	
7. Birth date of deceased (mo., day, yr.) <u>June 24, 1914</u>			
8. AGE: Years <u>33</u> Months <u>0</u> Days <u>22</u> If less than one day hrs. min.			
9. Birthplace <u>Sisterville West Virginia</u> (Town, county, and state)			
10. Usual occupation <u>Farmer</u>			
11. Industry or business			
FATHER			
12. Name <u>Wilson Laughery</u>			
13. Birthplace <u>West Virginia</u>			
MOTHER			
14. Maiden name <u>Goddie Cairnes</u>			
15. Birthplace <u>West Virginia</u>			
16. Informant <u>Mrs. Goldie G. Laughery</u> Address <u>Wilsonburg, West Virginia</u>			
17. <u>Burial</u> Date thereof <u>July 32-1947</u> (Burial, cremation, or removal. Which?) (month) (day) (year)			
Cemetery or crematory <u>Bridgeport Cemetery</u>			
Location <u>Bridgeport West Virginia</u>			
18. Funeral director <u>Shirley H. Watson</u>			
Address <u>Pocomoke City Md.</u>			
19. <u>July 19, 1947</u> R. D. Johnson M.D. (Date rec'd by registry) Registrar			
MEDICAL CERTIFICATION			
20. DATE OF DEATH <u>July 18 1947</u>			
21. I CERTIFY that death occurred on the date above stated: <u>that I attended deceased from</u> <u>and that I last saw him on</u> Immediate cause of death <u>Bullet wound of body & head</u>			
DURATION			
Due to			
Due to			
Other conditions			
(Include pregnancy within 3 months of death)			
Major findings or operations			
Date of op.			
Autopsy required			
PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, <u>suicide</u> , homicide, <u>suicide</u> Date of <u>7/18/47</u> Where the injury occurred <u>Pocomoke R.D. Somerset Md.</u> (City or town) (State) Injured at home, farm, industry, public place (where?) <u>Home</u> Means of injury <u>Bullet wound</u> Injured at work? <u>No</u>			
23. SIGNATURE <u>Henry M. Southard M.D.</u> M. D. or other Address <u>Brownsville Md.</u> Date signed <u>7/18/47</u>			

RECEIVED
JUL 22 1947
B. H. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. ~~Correct~~ age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06308 260

1. PLACE OF DEATH:

County SomersetCity or town New Pocomoke
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Del. County Som.City or town Pocomoke City, R.F.D.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Pearl Seal

3. (b) Social Security Number

4. Sex F5. Color or race col6. (a) Single, married, widowed, or divorced Not known6. (b) Name of husband or wife Not known7. Birth date of deceased (mo., day, yr.) Not known8. AGE: Years 38(?) Months 2 Days 1 If less than one day _____ hrs. _____ min.9. Birthplace Not known
(Town, county, and state)10. Usual occupation Not known11. Industry or business Not known12. Name Not known13. Birthplace Not known14. Maiden name Not known15. Birthplace Not known16. Informant Lehman EvansAddress Transient17. (Burial, cremation, or removal. Which?) Buried Date thereof July 10, 1947
(month) (day) (year)Cemetery or crematory Hickey, Va.Location Norfolk Co., Va. - Hickey18. Funeral director William A. James, Jr.Address Princess Anne, Md.19. 7/5 47 R. S. Johnson
(Date rec'd by registrar) (Year) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 19 47 at 3:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ to _____

and that I last saw him alive on _____

Immediate cause of death Shots wound of head

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 7/4/47Where did injury occur? New Pocomoke, Del. (City or town) (State)Injured at home, farm, industry, public place (where?) In labor shackMeans of injury Shots Injured at work? NoSignature Wm. R. Roubford, M.D.Address Princess Anne, Md. M. D. or other _____Date signed 7/5/47

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JUL 8 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06309

Reg. Dist. No. 260

1. PLACE OF DEATH:

County Somerset
City or town Princess Anne, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years
Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Somerset
City or town Princess Anne
(If outside city or town limits, write RURAL and give nearest town)
Street No. Washington Hotel
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME

JOHN LEONARD SHRIEVES

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Daisy Shrieves

6. (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1884

8. AGE: Years 63 Months 7 Days — If less than one day — hrs. — min. —

9. Birthplace Dames Quarter - Somerset - Md.
(Town, county, and state)

10. Usual occupation Hotel Owner & Manager

11. Industry or business —

12. Name Sandy Shrieves

13. Birthplace —

14. Maiden name Etta Shrieves

15. Birthplace Mt. Vernon, Md.

16. Informant Brady Shrieves

Address Princess Anne, Md.

17. Burial Date thereof July 20, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Marokim

Location Princess Anne, Md.

18. Funeral director Dale Dashiell

Address Princess Anne, Md.

19. July 18, 1947 (Date rec'd by registrar) Registrar John M. —

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18, 1947 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 21, 1947 to July 18, 1947
and that I last saw him alive on July 17, 1947

Immediate cause of death Carcinoma Stomach
DURATION 3 mos. and

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) (City or town) (County) (State)

Means of injury — Injured at work? —

23. SIGNATURE Thos B. Wallace, Jr. M.D. or other —

Address Princess Anne, Md. Date signed 7/18/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 22 1947
BUREAU
61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06310

Reg. Dist. No. 265

1. PLACE OF DEATH:

County SomersetCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 3310 B
(If rural, give LOCATION)2.(a) If veteran, name war None

3.(a) FULL NAME

Frederick Sterling

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Mary L

7. Birth date of deceased (mo., day, yr.)

May 11, 18625.(c) If alive, give age 80 years

8. AGE:

Years

Months

Days

If less than one day

85210

hrs.

min.

9. Birthplace

Cambridge
(Town, county, and state)

10. Usual occupation

Retired Bank Cashier

11. Industry or business

Bank of Cambridge

MOTHER FATHER

12. Name

John Sterling

13. Birthplace

MD

14. Maiden name

Sarah Mary

15. Birthplace

MD

16. Informant

Mary L Sterling

Address

3310 B Cambridge

17. (Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Cambridge

Location

Cambridge

18. Funeral director

William J. Green

Address

Cambridge, MD

19.

(Date reg'd by registrar)

19

47Janice E. Spies
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 19 47 at 9:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 19, 1946 to July 21, 1947and that I last saw him alive on July 19, 1947

Immediate cause of death

Arteriosclerosis

DURATION

2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

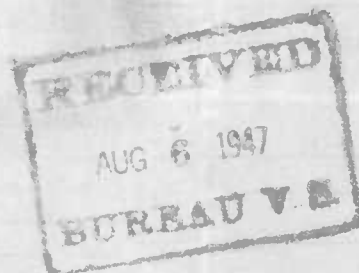
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Sarah M. Peyton M.D.
M. D. or otherAddress Cambridge, MDDate signed July 25, 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

66489

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:

County King George County (?)
 City or town Somerset County
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State unk. County

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Unknown

3. (b) Social Security Number

Sex Male 5. Color or race Black 6. (a) Single, married, widowed, or divorced 2

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) unk.

6. (c) If alive, give age years

8. AGE: Years unk. Months Days It less than one day
 hrs. min.

9. Birthplace unk.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name unk.
 13. Birthplace unk.
 14. Maiden name unk.
 15. Birthplace unk.

16. Informant
 Address

17. burial Date thereof aug 12 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory marionLocation marion md18. Funeral director Charles H WoodAddress marion md

19. Aug 12 19 47
 (Date rec'd by registrar) Registrar Janice E. Jones

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 19 47, at P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased

was dead when I saw
and that I saw him alive in water 19 47

Immediate cause of death

DURATION

AccidentalDue to drownedDue to William H. Coulbourn, M.D.

DEPUTY MEDICAL EXAMINER

FOR SOMERSET COUNTY, MD.

Other conditions Body decomposed
(Include pregnancy within 3 months of death)Major findings of operations no marks of foul play found

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Acc. Date of 7/30/47Where did injury occur? unk. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) PublicMeans of injury Unknown Injured at work? -23. SIGNATURE W. H. Coulbourn M.D.Address Somerset MD Date signed 8-11-47

RECEIVED
AUG 15 1947
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